TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
SOUTH TEXAS RADIOLOGY IMAGING CENTERS

Respondent Name
LIBERTY INSURANCE CORP

MFDR Tracking Number
M4-17-0171-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
SEPTEMBER 22, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Patient provided Workers Comp authorization at the time of service. Now our claim and request for reconsideration are being denied based on no authorization."

Amount in Dispute: $289.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT codes 64491, 64491-51 were denied with Pre-authorization was requested but denied for this service per DWC Rule 134.600…One facet joint nerve injection to bilateral T12-11 was authorized…denied as not authorized for medial branch blocks performed on T10-T11."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 11, 2016	CPT Code 64491 Facet Injection	$144.81	$144.81
	CPT Code 64491-51 Facet Injection	$144.81	$0.00
TOTAL		$289.62	$144.81

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, effective May 25, 2008, 33 *Texas Register* 3954, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600, effective March 30, 2014, requires preauthorization for specific services to include

3. 28 Texas Administrative Code §134.203 set out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 39-Code description not listed.
   - X388-Pre-authorization was requested but denied for this service per DWC rule 134.600.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - W3-Additional payment made on appeal/reconsideration.

Issues

1. Does a preauthorization issue exist in this dispute?
2. Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of the respondent denied reimbursement for CPT codes 64491 and 64491-51 based upon a lack of preauthorization.

   28 Texas Administrative Code §134.600(p)(12) requires preauthorization for " treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits)."

   On February 3, 2016, the requestor obtained preauthorization approval for "bilateral T12-L1 medical branch block."

   28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   A review of the submitted billing finds that the requestor billed for CPT codes 64490, 64490-51, 64491 and 64491-51 on the disputed date of service. These codes are defined as:

   - CPT code 64490 - "Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level." According to the explanation of benefits, the respondent paid for codes 64490 and 64490-51.
   - CPT code 64491 - "Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)."
   - Modifier 51- "multiple procedures"

   A review of the Operative report finds "Then under fluoroscopic guidance, 22 gauge needles were introduced with the tips at the expected location of the right T10, T11, and T12 medical branch nerves at the junction of T11-12 and L1…Then using the same technique, anesthetic blockade was performed at the T10, T11, and T12 medial branch nerves at the junction of the left T11, T12, and L1…"

   Based upon the code description only one facet joint injection should be reported per level regardless of the number of punctures required to obtain the block. Because preauthorization for "bilateral T12-L1 medical branch block" was obtained, two levels were approved. The Division finds that reimbursement is due for the additional level.

2. Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors

for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

Place of Service is 11-Office Based.

The 2016 DWC conversion factor for this service is 58.62.

The Medicare Conversion Factor is 35.8043

Review of Box 32 on the CMS-1500 the services were rendered in zip code 78240, which is located in San Antonio, Texas; therefore, the Medicare participating amount is based on locality "Rest of Texas".

Using the above formula, the division finds the following:

Code	Medicare Participating Amount	Maximum Allowable Reimbursement	Carrier Paid	Amount Due
64491	$91.25	$149.40 or less (Requestor is seeking $144.81)	$0.00	$144.81
64491-51	The requestor appended modifier 51 that is not appropriate with add-on code.			$0.00

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $144.81.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $144.81 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	11/30/2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.